

**Deposition Of:  
Debbie Fye**

April 24, 2017

Russell Pitkin and Mary Pitkin  
VS.  
Corizon Health, Inc.; et al.

Case No.: 3:16-cv-02235-AA



Debbie Fye

1 regarding HC standards. They put out new policies  
2 whenever NCCHC updates.

3 We've had some updates to some of our  
4 educational programs. We've had multiple  
5 reorganizations within the company with different  
6 roles and responsibilities. And that's what I can  
7 think of right at this moment.

8 Q. Was there an investigation performed by  
9 Corizon regarding Madaline Pitkin's death?

10 A. Yes.

11 Q. Who conducted it?

12 A. Multiple people.

13 Q. Can you give me the names of the multiple  
14 people?

15 A. Mandy Forsman, Leslie O'Neil.

16 Q. Sorry. Mandy Forsman? Hold on, just --  
17 Mandy Forsman?

18 A. I wasn't finished giving the list.

19 Q. I know. I'm just trying to understand  
20 what -- the first name, because we're trying to write  
21 things down accurately.

22 A. Mandy Forsman.

23 Q. And how do you spell Forsman?

24 A. Leslie -- I do not know.

25 Q. All right. Go ahead.

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1 A. Leslie O'Neil, Dr. Garlick, Dr. Orr, folks  
2 at corporate, and I'm not -- I'm not sure who at  
3 corporate would have reviewed the case.

4 Q. I'm sorry, which -- so after Mandy Forsman,  
5 who was the next person?

6 A. Leslie O'Neil.

7 Q. What's Ms. O'Neil's position?

8 A. At that time?

9 Q. Yes.

10 A. Director of nursing.

11 Q. And what's Ms. Forsman's position?

12 A. At the time, she was the health services  
13 administrator.

14 Q. And you listed -- after Ms. O'Neil, you  
15 listed two doctors?

16 A. Dr. Garlick --

17 Q. How do you --

18 A. -- and Dr. Orr.

19 Q. How do you spell -- is it Garlick?

20 A. G-A-R-L-I-C-K.

21 Q. And what's Dr. Garlick's position?

22 A. He's a regional medical director?

23 Q. And Dr. Orr?

24 A. O-R-R. He also was a -- was a regional  
25 medical director.

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1 Q. And you said some folks at corporate, but  
2 you don't know who?

3 A. That's correct.

4 Q. And were you involved in the investigation?

5 A. I was involved by reviewing the  
6 documentation. And I did speak to some of those  
7 involved.

8 Q. Did Corizon ever reach a conclusion as to  
9 what caused Madaline Pitkin's death?

10 A. I'm not aware if they did or they did not.

11 Q. Did Corizon ever reach a conclusion as to  
12 how Madaline's death could have been avoided?

13 A. I never heard anyone say that if this was  
14 done, the outcome could have been avoided. No, I did  
15 not hear that direct correlation.

16 Q. Well, I'm not asking if those specific words  
17 were said. I'm asking generally if Corizon, as the  
18 result of its investigation, figured out how to avoid  
19 deaths similar to that of Madaline Pitkin in the  
20 future?

21 A. I would have to say no, because each case is  
22 individual. Everyone's response is individual.  
23 Certainly, yes, we look at all our protocols, and if  
24 there's enhancements that need to be made. But I'm  
25 not sure that changing any protocol would guarantee a

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1 answer because not everything that you do in your  
2 quality improvement is -- you -- some things we keep  
3 confidential. So it's difficult to answer that. Some  
4 things, yes; and I'm going to say some things, no.

5 **Q. What things would you keep confidential from**  
6 **the county?**

7 A. Things that attorneys told -- conversations  
8 with attorneys, things like that.

9 Q. Other than conversations with attorneys,  
10 what other things are you aware of that you would keep  
11 confidential from the county?

12 A. Sometimes investigations might be kept  
13 confidential.

14 Q. Did Washington -- did Corizon share any of  
15 its investigation regarding Madaline Pitkin's death  
16 with the county?

17 A. I don't know.

18 Q. Do you know -- do you know if the county  
19 asked for it?

20 A. I don't know. If they did, I don't  
21 remember.

22 Q. All right. Is that what's called a sentinel  
23 event investigation?

24 A. Not necessarily.

25 Q. What is a sentinel event investigation?

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1           A. A sentinel event investigation is an  
2 investigation where it was -- someone determined that  
3 the outcome of the patient is something that is  
4 unexpected or is a outcome such as death.

5                 For instance, at one point, any patient who  
6 had a suicide attempt, we would consider that a  
7 sentinel event.

8           Q. And was a sentinel event investigation  
9 performed regarding Madaline Pitkin?

10          A. I believe so, yes.

11          Q. Do you know who performed that  
12 investigation?

13          A. I do not know who was in charge of it. I  
14 know that there were multiple people involved.

15          Q. And were those the individuals that you  
16 previously provided me their names?

17          A. Yes.

18          Q. And were there records maintained regarding  
19 the sentinel event investigation as it relates to  
20 Madaline Pitkin's death?

21          A. I -- I don't know what Corizon has and what  
22 Corizon doesn't have. I would have no way of knowing  
23 that.

24          Q. Is it your understanding that records are  
25 maintained regarding sentinel event investigations?

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1           A. I would agree that at times, there are  
2 written reports. But how long they're kept, that, I  
3 wouldn't know.

4           Q. Okay. I -- I guess we misunderstood each  
5 other. I wasn't asking how long they were kept. But  
6 it's your understanding that a sentinel event  
7 investigation is documented, correct?

8           A. I have never been at corporate during a  
9 sentinel event investigation with a sentinel event  
10 committee. So I really can't speak to what they do  
11 when they're compiling the -- they gather the  
12 information, and then there's a committee meeting.  
13 I've never been involved with that so I'm not sure  
14 what they do or what documentation they might have.

15          Q. What the's purpose of a sentinel event  
16 investigation?

17          A. I think there's several purposes. One,  
18 trying to determine factually what happened. Also, is  
19 there anything as a company we can do to improve  
20 practices that possibly could assist in preventing a  
21 similar incident.

22           I think those probably are the two main  
23 reasons. But again, I would have to look at the  
24 policy on sentinel event to be able to tell you  
25 exactly what the company's intention is.

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1           Q.    Sure.   But conceptually, it makes sense to  
2        you that the company would want to know factually what  
3        happened and also figure out if there was a way to  
4        prevent it from happening in the future, correct?

5           A.    I think that we would want to look if there  
6        was things that we could do different as a company or  
7        as a site.   But unfortunately, everything we do in  
8        medicine carries risk.   And we can't always predict  
9        what those risks are or how someone is going to  
10      respond to either a modality of treatment or no  
11      treatment at all.   So all as we can do is  
12      retrospectively look at things and say, you know, is  
13      there anything that might be better for us to do in  
14      the future.

15           Q.    And you would look at it to determine if  
16        there's a way for you to prevent it from happening  
17        again, correct?

18           A.    Well, you can't always predict -- you can't  
19      always predict an outcome.   You can't predict that if  
20      we do this, we're not going to have this outcome  
21      because of the inherent risks.   And everyone is an  
22      individual.   But you can come to a conclusion that --  
23      that through studying it can say that, yes, if this is  
24      done, there's a less chance you'll have a complication  
25      and the outcome might be better.

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1 Q. So stated simply, you want to know what  
2 happened and find out if there's a way to avoid it in  
3 the future, correct?

4 A. No. I didn't say avoid it in the future. I  
5 said anything we can do different in our practices so  
6 that we could have a better outcome or a different  
7 outcome. But again, we can't predict the outcome  
8 because of the inherent risks of medicine.

9 Q. My question is very simple.

10 Do you want to perform the investigation so  
11 you can try to avoid the same thing happening again,  
12 or not?

13 MR. HANSEN: Objection. Asked and answered.  
14 Go ahead.

15 BY MR. COLETTI:

16 Q. Go ahead.

17 THE DEPONENT: Answer it?

18 A. Again, we do it so that we can review what  
19 happened and look to see if there's any practices or  
20 procedures or anything else we could do differently in  
21 the future that would have a better result or the  
22 outcome might be different. But, again, there's  
23 inherent risk. You can't -- you can't say that if you  
24 do this, you will never have this outcome. That's  
25 almost impossible to say in medicine.

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1 differently to prevent something from happening again,  
2 correct?" )

3 A. And I said no to that because it said  
4 prevent something from happening again. And again,  
5 you cannot predict outcomes in medicine because of  
6 inherent risks.

7 And I further said earlier that there is a  
8 policy on sentinel event that completely explains the  
9 workings of a sentinel event and the purpose of it.  
10 And if I had that in front of me, I could give you  
11 more information.

12 BY MR. COLETTI:

13 Q. Was a sentinel event investigation performed  
14 regarding Madaline Pitkin's death?

15 A. To my knowledge, yes.

16 Q. And have you reviewed that?

17 A. No, I have not.

18 Q. Do you have any idea, as the vice president  
19 of the region where Ms. Pitkin died, regarding the  
20 contents of that investigation?

21 A. No. I -- I never saw the report.

22 Q. Do you have any explanation as to why, as  
23 the vice president for the jail where Ms. Pitkin died,  
24 you've never seen the sentinel event -- event  
25 investigation?

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1 A. Because that's not part of my role.

2 Q. Why isn't -- why isn't that important to  
3 your job?

4 A. Sentinel event committee is who handles the  
5 sentinel event.

6 Q. But wouldn't you want to know the results of  
7 their investigation, since you're in charge of the  
8 Corizon employees at that facility?

9 A. Not necessarily. What I would want to know  
10 is if there were any recommendations.

11 Q. So let's make sure we understand each other.  
12 You were the vice president of Corizon in charge of  
13 the Washington County jail, correct?

14 A. Yes.

15 Q. You were responsible for the employees  
16 there, correct?

17 A. Define responsibility.

18 Q. You were the boss.

19 A. I was over the site, yes.

20 Q. You could hire and fire employees at Corizon  
21 at the Washington County jail, correct?

22 A. No. The hiring was done by the health  
23 services administrator and the director of nursing.

24 Q. Okay. But as it relates to the discipline  
25 of the employee, you were the boss, correct?

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1 reasons?

2 A. If there was changes in policies, I would  
3 communicate that to the HSA.

4 Q. All right. So if somebody, then, did a  
5 sentinel event investigation and reached a conclusion  
6 regarding the cause of Ms. Pitkin's death, is that  
7 something you would want to know as the individual in  
8 charge of the staff at that jail?

9 A. I would not necessarily need to know the  
10 cause of Ms. Pitkin's death to do my job.

11 Q. That wasn't my question.

12 Would you want to know the results of the  
13 investigation, given your responsibility for the  
14 individuals at that jail? Yes or no?

15 A. No.

16 Q. You're not -- you wouldn't be the least bit  
17 interested in it?

18 A. Doesn't matter if I would be interested,  
19 sir. I'm not given the results of sentinel events  
20 completed at any facility.

21 Q. I'm not --

22 A. That's handled by the sentinel event  
23 committee.

24 Q. Well, you just said you wouldn't be  
25 interested in knowing what caused her death, despite

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1 can only make an assumption as to why he would call  
2 the sheriff. But he did have responsibility for the  
3 site.

4 Q. And do you have any information as to why  
5 Mr. Vaughan would have called the sheriff to state  
6 that he was doing a review of Ms. Pitkin's death and  
7 they are working on it so it doesn't happen again?  
8 Did you ever discuss that with Mr. -- did you ever  
9 discuss that with your boss?

10 A. Not to my recollection. And I wouldn't know  
11 why he does what he does. You'd have to ask him.

12 Q. So at no time did you and your boss sit down  
13 to discuss the review of Ms. Pitkin's death and what  
14 you guys were going to do so it didn't happen again,  
15 correct?

16 A. We might have discussed recommendations, but  
17 they wouldn't be a direct result of Ms. Pitkin's  
18 death.

19 Q. All right. So it is -- is it accurate or  
20 inaccurate to state that Corizon did a review into  
21 Ms. Pitkin's death to determine how to prevent it from  
22 happening again?

23 A. As I said before, Corizon did do an  
24 investigation into the events leading up to  
25 Ms. Pitkin's death. And there were recommendations

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1 made generally for improvements that might be made or  
2 changes that might be done locally in the care of all  
3 patients, but not directly related to Ms. Pitkin's  
4 death.

5 Q. Okay. And what were those recommendations?

6 What were the changes that were made?

7 A. Over what period of time?

8 Q. At any period of time. At any time period.

9 MR. HANSEN: Are we talking about post --  
10 post Pitkin?

11 MR. COLETTI: Yes.

12 A. There was auditing done of site functions by  
13 a multitude of people, and there were recommendations  
14 made. And those are the recommendations that were  
15 implemented.

16 We looked at our intake procedures. We  
17 looked at staffing levels and increased the nursing  
18 staff. We looked at medication administration and  
19 made some changes to medication administration. We  
20 had documentation education and made some changes to  
21 documentation. And I'm sure there's others that don't  
22 come to mind right now.

23 BY MR. COLETTI:

24 Q. Okay. Let's walk through those. What were  
25 the changes to education administration?

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1 CERTIFICATE  
2

3 I, Marcel N. Johnson, Certified Shorthand Reporter  
4 for Oregon and Washington, and a Registered  
5 Professional Reporter, do hereby certify that DEBBIE  
6 FYE personally appeared before me at the time and  
7 place set forth herein; that at said time and place I  
8 reported in stenotype all testimony adduced and other  
9 oral proceedings had in the foregoing matter; that  
10 thereafter my notes were transcribed using  
11 computer-aided transcription under my direction; and  
12 the foregoing transcript constitutes a full, true and  
13 accurate record of such testimony adduced and oral  
14 proceedings had and of the whole thereof.

15 Witness my hand and stamp at Portland, Oregon, this  
16 4th day of May, 2017.

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